ADAMI (J.G.)

A rare form of
Subs. diaphragmatic abscess.

SURF

# A RARE FORM OF SUB-DIAPHRAGMATIC ABSCESS.

BY

PROFESSOR J. G. ADAMI, M.A., M.D.,

From the McGill Pathological Laboratory.

*Reprinted from the Montreal Medical Journal, March,* 1894.

# A RARE FORM OF SUB-DIAPHRAGMATIC ABSCESS.*

By Professor J. G. Adami, M.A., M.D.
(From the McGill Pathological Laboratory.)

It is not a little noticeable how silent are even the best and most modern text books upon the subject of sub-diaphragmatic abscess, with a silence that is out of proportion to its diagnostic and clinical interest, and it may be added to its relative frequency. Doubtless the fact that the subject cannot be treated under the heading of any one special organ, leads to its being neglected in well-ordered text books. so that information has still to be gathered from scattered papers. Thus it happens that although I am acquainted with a fair number of cases in which the original disturbance has originated in connection with the liver, kidney, spleen or stomach, I have been able to find none presenting the anatomical features of the case here recorded, though such must exist.†

The patient, L. F., sixty-five years old, was received into the General Hospital, under Dr. Molson, upon October 3rd, in a state of semi-collapse. All that could be ascertained as to his previous history was that for the past four or five days he had been suffering from pain in the epigastrium, thirst, restlessness and pains in the joints. He died within twenty-four hours, before time had been allowed for a full diagnosis. The pulse was almost imperceptible, there was a large area of cardiac dulness, the heart sounds could scarcely be heard, while no murmur could be detected. Over the region of the liver in front there was acute pain upon pressure. The respiratory sounds were tubular. A provisional diagnosis was made of pericarditis.

At the autopsy performed upon October 5th, the following were the more important conditions observed. The skin of the whole body had a slight yellowish tinge. The pleural cavities contained about eight ounces of clear serum. The lungs were

* Read in abstract before the Montreal Medico-Chirurgical Society, Nov. 3rd, 1893.

† Petri, Dissertation, Berlin, 1868, quotes a case of sub-diaphragmatic perforation of the œsophagus following upon cancer, but of the extent of the succeeding inflammation I cannot clearly learn, not having the original by me.

very œdematous, showed some slight signs of anthracosis, and in either apex were found evidences of an old and cicatrised tuberculous condition. The pericardial cavity was enormously distended, the fluid was milky with numerous flocculi floating therein. The heart was covered over with a layer of inflammatory lymph ; and its cavities were filled with well-formed clots, firm and rather pale, together with some fluid blood. The lower and inner half of the parietal pericardium was thickened, and upon cutting into it, down upon the diaphragm an abscess cavity was exposed lying between diaphragm and pericardium. This was of irregular shape and contained a quantity of thick creamy pus. Upon inspecting the abdomen, a large abscess was found beneath the diaphragm, having in its centre the abdominal end of the œsophagus and the cardiac end of the stomach. This extended to the left edge and under the surface of the left lobe of the liver on the one side ; on the other it almost touched the splenic flexure of the colon and the surface of the spleen. It was filled with a thinner greyish pus, and communicated through the diaphragm with the supra-diaphragmatic abscess. The cardiac orifice of the stomach was discovered to be greatly stenosed and ulcerated. Further inspection revealed that there was a ring of cancerous growth implicating the gastric mucous membrane, and forming a ring varying in breadth from 2 to 3 cm. around the cardiac orifice ; the growth extended a short distance up the œsophagus. Microscopical examination showed the cancer to be primarily gastric —that is to say, it was of the nature of a columnar celled carcinoma. It infiltrated all the coats of the stomach.

No actual perforation of the stomach or œsophagus was to be discovered.

It would seem evident that the history of the case was one primarily of cancer of the cardiac orifice of the stomach leading to stenosis ; ulceration of the cancer, and extension of the septic process through to the serous surface of the organ—or, it may have been, perforation above the stenosed area by a fish bone or other fine spicule, the passage closing behind the foreign body ; suppuration around the termination of the œsophagus

leading to a sub-diaphragmatic abscess; extension of the process through the diaphragm; inflammation of some little standing of the outer layers of the parietal pericardium; extension through the pericardium; purulent pericarditis; death.

Judging from the condition of the sub-diaphragmatic abscess, and the want of well-defined boundary, this had of late been extending rapidly.

There is a possible alternative that the supra-diaphragmatic abscess with its more creamy pus was of the earlier origin, but this I think is improbable. The presence of the gastro-œsophageal carcinoma in such characteristic relationship to the surrounding sub-diaphragmatic abscess, renders the former the more likely course of events.

U. S. DEPART

WE

# CURRENTS

DEDUCED FROM THE MO

SEASONS